Suffolk Safeguarding Adults Board

‘M’ Case Study – Fire Risks for non-mobile people.

M’s Story.

M suffered from a serious degenerative health condition and after being transferred from a care home lived alone in a new build, adapted Local Authority bungalow.

M was described by medical professionals as being clinically obese and a heavy smoker. In addition, M required support with her personal care requiring the use of a hoist to be transferred to and from her bed, a specially adapted wheelchair and other modifications to the property to assist with her everyday life.

Most of her social contact was provided by carers who visited four times a day. In addition to personal care they provided advice and support, including their expressed concerns about M smoking in bed. Carers also recorded ‘burn marks’ on M’s bedding and clothes and advised her accordingly.

Smoke alarms were fitted to the property, but these were not linked to a central call centre, therefore any emergency calls would have to be made by M herself in the event of a fire. Due to difficulties with mobility M would be unable to escape unaided in the event of a fire.

In January 2017, on arrival the carers noticed smoke coming from the property and raised the alarm. Despite the efforts of the Fire Service and neighbors, M died as a result of the fire.

There were no electrical faults in the property and all safety devices were fitted, it was concluded that M died as a result of a fire caused by smoking in bed.

It was felt that some of the emollients in medical pads issued to M, had potentially contributed to spread of the fire.

What went well?

- M’s support needs were being met and she had good support from her carers.
- There was extensive Social Care involvement in this case.
- The property M lived in was specially adapted to meet her needs.
- Efforts were made to advise M on the dangers of smoking in bed.

What were we worried about?

- M ignored advice to stop smoking in bed despite the risks being made clear to her by her carers.
- There was little evidence of care workers raising their concerns about the fire risks with their managers or Social Workers.
- There was no evidence of environmental fire risk assessment being carried when M was moved from a care home to her bungalow.
- There was no way M could easily make a call for help in an emergency due to her medical condition.
- There was little recognition that the medical pads contributed to the increased fire risk.

What is the learning from this case?

- There needs to be better sharing of information between commissioners and independent care providers regarding the potential fire risks of non-mobile patients who smoke.
- Person centred fire risk environmental assessments need to be an integral part of care planning.
- There is an increased fire risk for patients being treated with a paraffin-based emollient product that is covered by a dressing or clothing, there is a danger that smoking or using a naked flame could cause dressings or clothing to catch fire.
- Smoking cessation programmes are included in person centered support plans.
- A system e.g. Telecare would notify the Fire Service of a fire if patients are unable to make contact easily.